MAP 14
(4/14)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
AUTHORIZED REPRESENTATIVE

If you can not come to the office and apply for Medicaid, you may call the Department for Community Based Services (DCBS) office in the county where you live and other arrangements may be made. If you want someone to make an application for you, please fill out the information below.

I _____ have asked_____
(Print Your Name) **(Print Authorized Representative's Name)**

to apply for Medicaid for me. This authorization is valid from the date of applicant's signature until at which time the form is rescinded by the applicant.

I give my permission for the above person to apply for Medicaid for me because I can not come to the local office of the Department for Community Based Services (DCBS) and do not want other arrangements to be made. I can not come to the DCBS office because:

_____

I understand that I or my authorized representative must provide complete and truthful information to have my Medicaid eligibility determined.

If I or my authorized representative knowingly provides false information or withholds information I may be subject to prosecution for fraud.

Eligibility determinations may take up to 30 days from the date of application to be completed. DCBS will contact you to confirm information provided by your authorized representative. All identification cards and letters will be mailed to your address. You will need to show your identification card to your medical providers so they can bill Medicaid for the services you received.

_____	_____
Your Signature	Authorized Representative Signature
_____	_____
Address	Address
_____	_____
City/State/Zip	City/State/Zip
_____	_____
Phone number	Phone number
_____	_____
Date	Date
_____	_____
Witness (if signed by an X)	Company Name (if Appropriate)/Relationship